

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
7 9 2 3 3 5 8									
1- FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Enoch Leroy Baker				2a. DATE OF DEATH MONTH DAY YEAR 9-23-79		2b. HOUR 9:40 AM			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 7-21-04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS N. Main St.	
14. FATHER'S NAME FIRST MIDDLE LAST Enoch L. Baker, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Cahall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS Florence Cannon Greensboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronch Stem Stroke 436- DUE TO, OR AS A CONSEQUENCE OF: (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1972 9/23 79		22a. I certify that (I) (this hospital) attended the deceased from 9/23 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Wm H Wood Jr				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood Jr MD				22e. ADDRESS EASTON, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-26-79		23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md.			
24. FUNERAL DIRECTOR NAME John E Boudais				25a. DATE REC'D. BY REGISTRAR SEP 27 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady			

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• **What is the main point?** •

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John L. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 2 3 3 5 9	
FOR 1 - STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Clare	MIDDLE M.	LAST Bender	2a. DATE OF DEATH MONTH DAY YEAR 9 - 27 - 79
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bozman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John W. May			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary T. Lane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-30-2529		17. INFORMANT ADDRESS P.O. Box 216 William Arthur Bender Bozman, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>peritonitis</u> 5621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ruptured sigmoid diverticulum</u> (c) <u>due to, or as a consequence of</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION 5/20/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated diverticulum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>James C. Gieske</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/28/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Gieske, M.D.		22e. ADDRESS 108 N. Washington St. Easton, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-2-79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville Prince Georges
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		24b. ADDRESS 200 S. Harrison St. Easton, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 0 3 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony A. Brady</i>



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MIDDLE LAST Helen Marie Beulah				MONTH DAY YEAR Sept. 9, 1979				3 ³⁰ PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Negro		MONTH DAY YEAR November 4, 1921		57 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Jonestown, Md.		U.S.A.				Talbot MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		The Memorial Hospital				Housewife		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
13a. STATE COUNTY Maryland Caroline				13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. Rt. 2, Box 288			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Albert Jones				FIRST MIDDLE LAST Alberta Strawberry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				219-05-0685		Maryland 21632 Arville Beulah, Rt. 2, Box 288, Federalsburg,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA TISSUS</u> 1533 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA. SIGMOID</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>LIVER METS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS 21 YR									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6-15-79			CA. SIGMOID			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
<u>John I.F. Knud Hansen</u>						M.D.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
John I.F. Knud Hansen, M.D.						Easton, Maryland 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Sept. 15, 1979		Federal Hill		Federalsburg, Caroline, Md.		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ernestine - Houshins Box 43 Federalsburg, Md.						SEP 17 1979		<u>John I.F. Knud Hansen</u>	

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Exhibit the agreement between

Exhibit

Exhibit

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR				REG. NO. 7 9 2 3 3 6 1					
1. DECEASED NAME (TYPE OR PRINT) Ernestine C. Bishop				2a. DATE OF DEATH MONTH DAY YEAR 9-13-79				2b. HOUR 9:35 PM	
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 7-31-12		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Md.									
13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Sunset Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST John Carroll				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stelle Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO 219-03-2396		17. INFORMANT ADDRESS Davis N. Bishop Greensboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Myocardial Infarction.</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Atherosclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis with cerebral vascular insuff.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>79</u> , to <u>Sept 13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Sept 13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard F. Manegold				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/14/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Manegold, M.D.				22e. ADDRESS Easton, MD 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-79		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md.			
24. FUNERAL DIRECTOR NAME John E. Boulton				25a. DATE OF REGISTRATION Sept 13 1979		25b. REGISTRAR'S SIGNATURE			

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Monmouth

James Ave.

x

Windsor

Caroline

Iselle Murphy

John Carroll

213-03-3300 Davis St. Newark, N.J.

no

Isabelle Murphy - 213-03-3300

9-12-75

John

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1. STATE REGISTRAR					7 9 2 3 3 6 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Franklin Boyce					9-30-1979				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9-4-09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7b. HOUR 8:40 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talebot		10. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridiana P		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Canning Co.		MD.	
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Holly Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Boyce		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Cousin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-8602		17. INFORMANT ADDRESS Dora Boyce Greensboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>7-21</u> 19 <u>79</u> , to <u>7-25</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7-25</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u>		DEGREE M.D.		22c. DATE SIGNED 10-2-79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.	
22e. ADDRESS Easton, MD 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-3-79		23c. NAME OF CEMETERY OR CREMATORY Cokers Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md.			
24. FUNERAL DIRECTOR NAME <u>John E. Boulos</u>		ADDRESS <u>Greensboro</u>		25a. DATE RECEIVED BY REGISTRAR 10/8/79		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			



Male

2-1-73

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W.L.A.

W.

Canning Co.

Lumber

July 23.

x

Caroline Greenhouse

W.

Marion Conain

Frank Boyce

21-11-1973 Post Office Greenboro, N.C.

no

Greenboro, N.C.

Post Office

21-11-73

Post

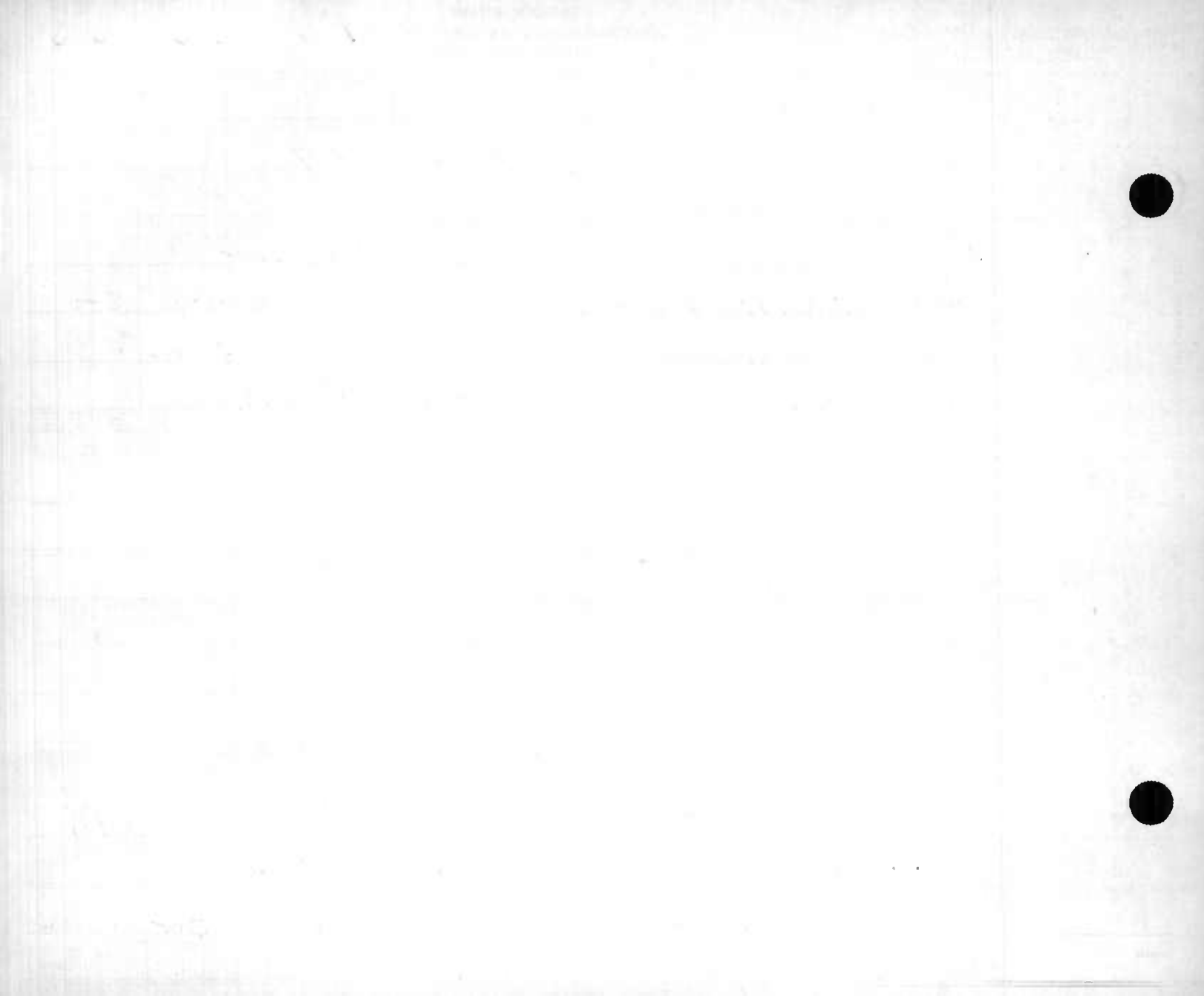
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	2	3	3	6	3
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Matthew Brown</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>9-19-79</i>				2b. HOUR <i>5:45</i> AM		
3. SEX <i>Male</i>			4. RACE <i>20940</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>3 30 20</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.							
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>md</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>South St</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>James Brown</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virginia Brown</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>					16b. SOCIAL SECURITY NO. <i>224-369361</i>		17. INFORMANT <i>Hosp. Records</i>					ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Crohn's carcinoma, metastatic</i> <i>1509</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 mos</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1978</i> to <i>Sept 1979</i> , that (I) (we) last saw the deceased alive on <i>9/14</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>J.C. Gieske</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/19/79</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.C. Gieske</i>			22e. ADDRESS <i>Easton, Maryland 21601</i>													
23a. BURIAL, CREMATION, REMOVAL <i>(SACRIFICE)</i>			23b. DATE <i>10/21/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>md Vet. Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Haverlock Prince Georges Md</i>								
24. FUNERAL DIRECTOR NAME <i>George H. DASHER</i>							ADDRESS <i>F/H Easton Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 10 1979</i>			25b. REGISTRAR'S SIGNATURE <i>History McQuay</i>			

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH				2c. DATE ESTI-MATED				2d. HOUR			
CHARLES		HENRY		BUTLER		9/26 1979				9/26 1979				30 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR					
Male	B	2 7 23		56 YRS.		MONTHS		DAYS		SEPT. 26 1979				30 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				MD			
NJ		US		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		TALBOT							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Easton		The Memorial Hospital		Laborer															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md		TALBOT		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 1											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Charles H. Butler		Eleanor Butler																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		215-18 4499		Charalle Butler		44 Greenbush													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
410 -		IMMEDIATE CAUSE (a) Coronary Thrombosis		Hours															
		DUE TO, OR AS A CONSEQUENCE OF																	
		(b) Aortic + gen. Arterial Sclerosis																	
		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION															
				STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my apinian																	
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Louis A. Merty		M.D. for D		9-26-79															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
WELTY EASTON																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Burial		10/3/79		Joy Town		Easton Trl													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Dwight Dashiell P.O. Box 606 Easton		OCT 3 1979		Randy Anthony															

BP

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

7 9 2 3 3 6 5

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT CLARK		2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 18, 1979		2b. HOUR 20 MIN. 8 A. M.	
3 SEX Male		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1-20-12	
6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) The Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY Construction		13a. STATE Md.		13b. COUNTY Caroline	
13c. CITY OR TOWN Ridgely		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS Henry Rd.	
16a. FATHER'S NAME FIRST MIDDLE LAST Robert Clark		16b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Baynard			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		17b. SOCIAL SECURITY NO. 137-18-3589		17. INFORMANT ADDRESS Wilhemina Clark Ridgely, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Dis. 4140 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 79	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I (this hospital) attended the deceased from Sept 16, 1979 to Sept 18, 1979 , that (we) lost saw the deceased alive on Sept 18, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death.		22b. SIGNATURE R. Lane Wroth, M.D. DEGREE	
22c. DATE SIGNED 9-19-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.		22e. ADDRESS St. Michaels, Maryland 21663	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-22-79		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Goldsboro Caroline Md.		24. FUNERAL DIRECTOR NAME ADDRESS J. E. Bonlain Greensboro, Md.		25a. DATE REC'D. BY REGISTRAR SEP 24 1979	
25b. REGISTRAR'S SIGNATURE Robert M. Brady					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

M

x

x

SECRET

SECRET

no

127-18-1000

SECRET

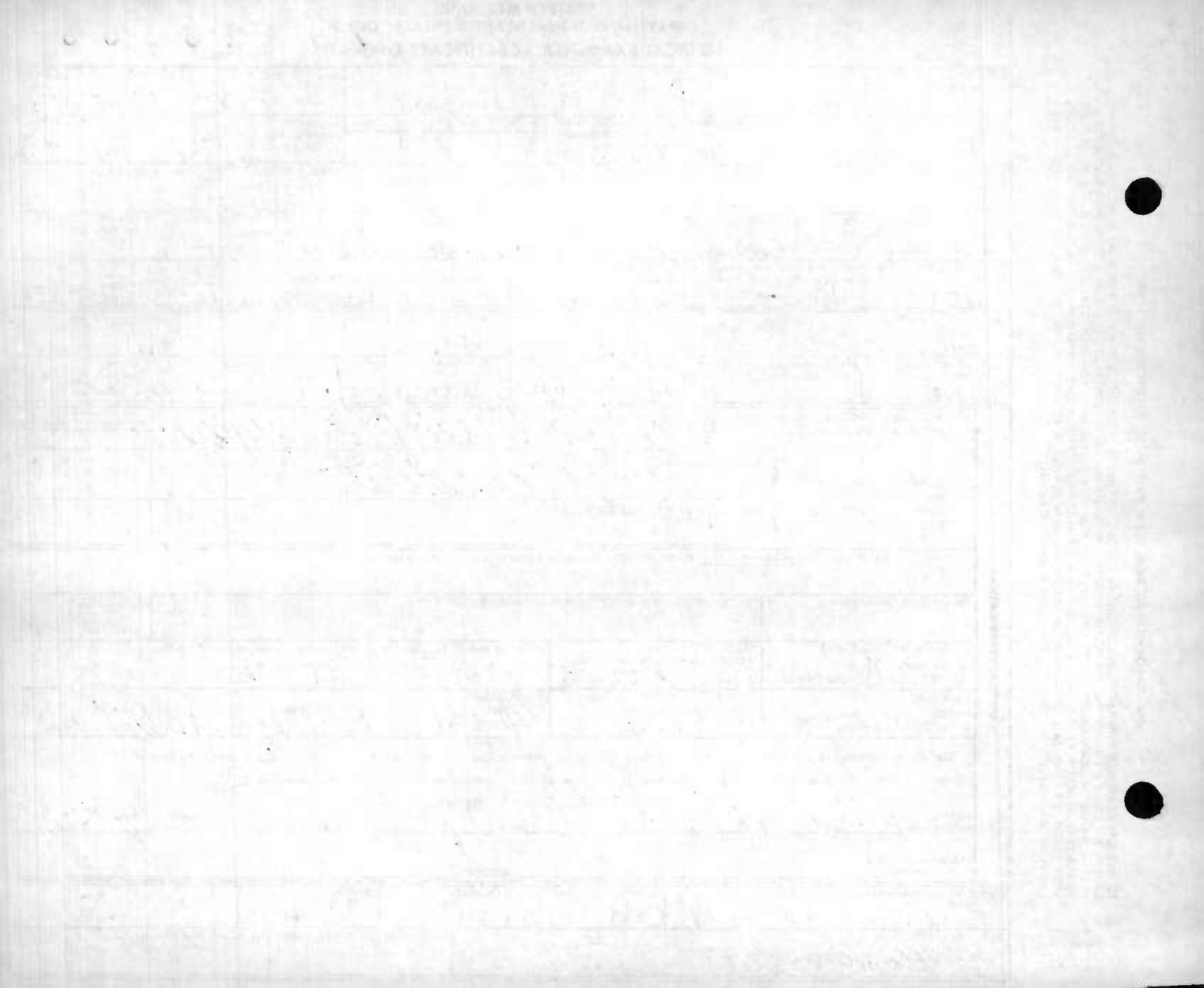
SECRET

DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR					
JEAN		P.		DAVIDSON				9		27		19		79		11		12					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR					
F		Cauc.		8 10 42		37 YRS.		MONTHS		DAYS		HOURS		MIN.		9-27		1979					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Delaware				USA								TALBOT											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
EASTON				EASTON Mem. Hospital				GUIDES Corp.															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Del.				Kent				Dover				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Lake and TR. G, Lot 31							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
ERNEST				Mina Hill																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
NO				222-26-4706				Wanda Hill				Dover, De.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <u>Multisystemic organ failure</u>																							
8147 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying</u> cause last.																							
(b) <u>Auto accident</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>1:50 P.M.</u> MONTH <u>9</u> DAY <u>27</u> YEAR <u>1979</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
								ran in front of car															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE			
				highway				RD 331				Easton				Talbot Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)												MEDICAL EXAMINER				DATE SIGNED			
R. Paul Whitt				Deputy																9-28-79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Burial				10-2-79				Odd Fellows Cem.				Milford				De.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
William C. Dorbert				Dover, Del.				OCT 5 1979				[Signature]											



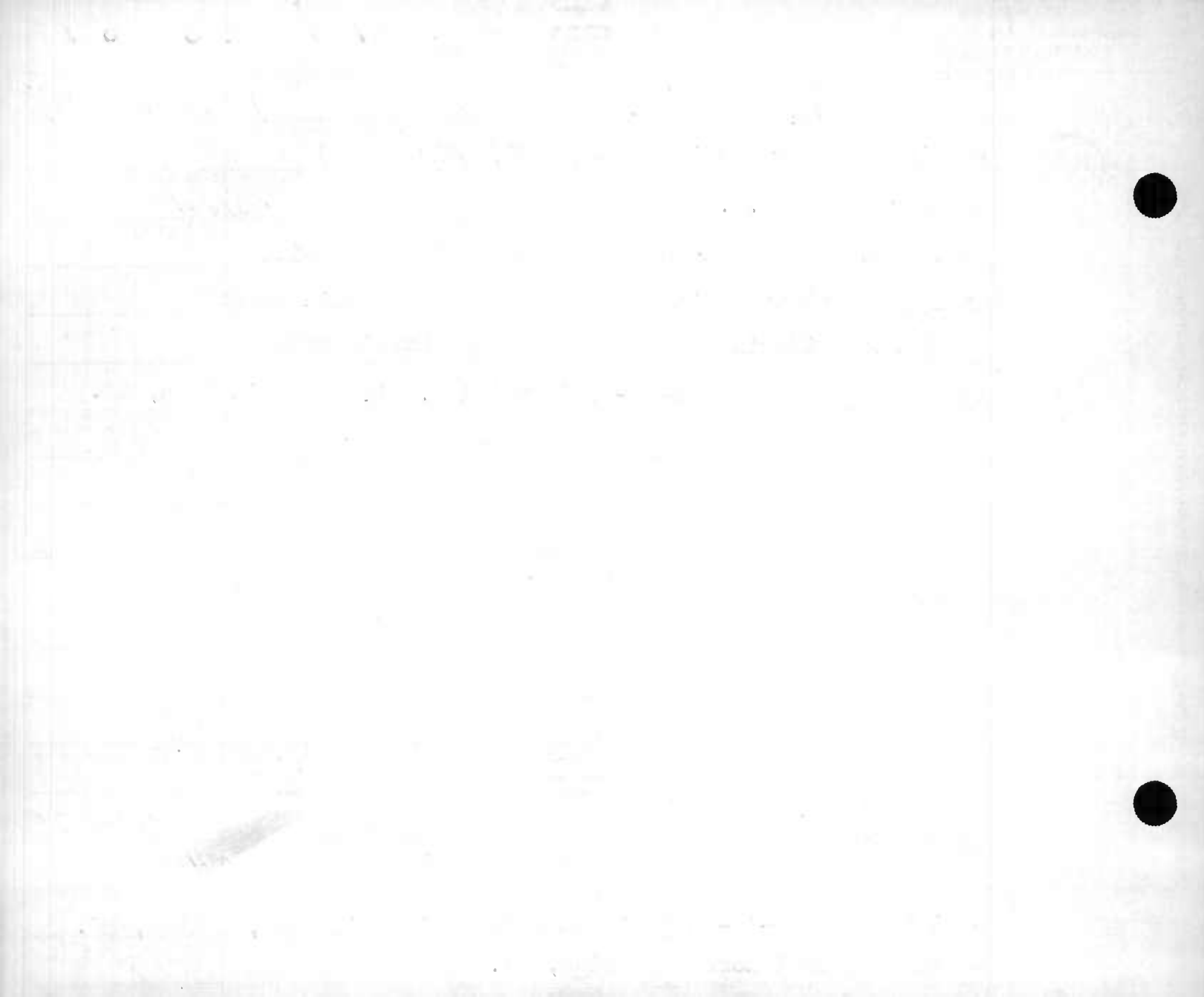
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thelma Louise Dize</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 13 1979</i>			2b. HOUR <i>11²² AM</i>				
3. SEX <i>female</i>		4. RACE <i>caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 23, 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD				
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Tilghman</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Main Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Kitching</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie Evans</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>231-14-4751</i>		17. INFORMANT ADDRESS <i>Daniel A. Dize Tilghman, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>intracerebral hemorrhage</i> <i>431-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hr</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>RHD & Prosthetic Valve Debridement Mellets</i>										
19a. DATE OF OPERATION <i>9/13/79</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Debridement Mellets</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/13 1979</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/13</i> 19 <i>79</i> , to <i>9/13</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>9/13</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Wm Wood</i>					DEGREE <i>MD</i>			22c. DATE SIGNED <i>9/13/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm Wood</i>					22e. ADDRESS <i>Easton Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9-16-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Tilghman Methodist</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Tilghman, Talbot, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>					ADDRESS <i>Easton, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Marky McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH	
FIRST MIDDLE LAST AL Fred M. Dobson		MONTH DAY YEAR Sept. 2, 1979	
3 SEX		2b HOUR	
male		6:45 P.M.	
4 RACE		6 AGE (IN YEARS LAST BIRTHDAY)	
caucasian		69 YRS.	
5. DATE OF BIRTH		8 IF UNDER 1 YEAR	
MONTH DAY YEAR Apr. 1, 1910		IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9 BALTIMORE CITY OR COUNTY OF DEATH	
Delaware		TALBOT MD.	
7b CITIZEN OF WHAT COUNTRY?		10 CITY OR TOWN OF DEATH	
U.S.		EASTON	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
		memorial	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
truck driver		Concrete Prod	
13a STATE		13b CITY OR TOWN	
Maryland		Trape	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST James A. Dobson		FIRST MIDDLE LAST Nora Schwaninger	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
no		212-12-3456	
17 INFORMANT		ADDRESS	
Loretta C. Cecil		409 Salmon Avenue Easton, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CVA			
4292			
DUE TO, OR AS A CONSEQUENCE OF			
(b) ASCVD			
DUE TO, OR AS A CONSEQUENCE OF			
(c) Cerebral			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Ca of Lung			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19	
21d INJURY OCCURRED		21e PLACE OF INJURY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f LOCATION	
		STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 8/19/79, 1979, to 9/2/79, 1979, that (I) (we) lost saw the deceased alive on 9/2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE		DEGREE	
William J. Banfield		M.D.	
22c DATE SIGNED		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
9-4-79			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS	
William J. Banfield, M.D.		Easton, Maryland 21601	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		9-5-1979	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Spring Hill		CITY OR TOWN COUNTY STATE Easton, Talbot, Md.	
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR	
NAME ADDRESS Newnam Funeral Home Easton, Md.		25b REGISTRAR'S SIGNATURE SEP 7 1979	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Doris Ann Downes			2a. DATE OF DEATH MONTH DAY YEAR September 8, 1979			2b. HOUR 1:26 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dietary Aide	
						12b. KIND OF BUSINESS OR INDUSTRY Public School	
13a. STATE Maryland			13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centreville		
14. FATHER'S NAME FIRST MIDDLE LAST William Edward Pinder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Marie Blaxton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-05-7647		17. INFORMANT Daughter Miss Cathy A. Downes, Centreville, Md. 21617			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1970, to Sept 8, 1979, that (I) (we) last saw the deceased alive on Sept 7, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John R. Smith, Jr.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr., M.D.		22e. ADDRESS Centreville, Md. 21617					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Chesterfield		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md.	
24. FUNERAL DIRECTOR NAME Barton Bros. James H. Barton, Jr., Centreville, Md. 21617				25a. DATE REC'D. BY REGISTRAR SEP 14 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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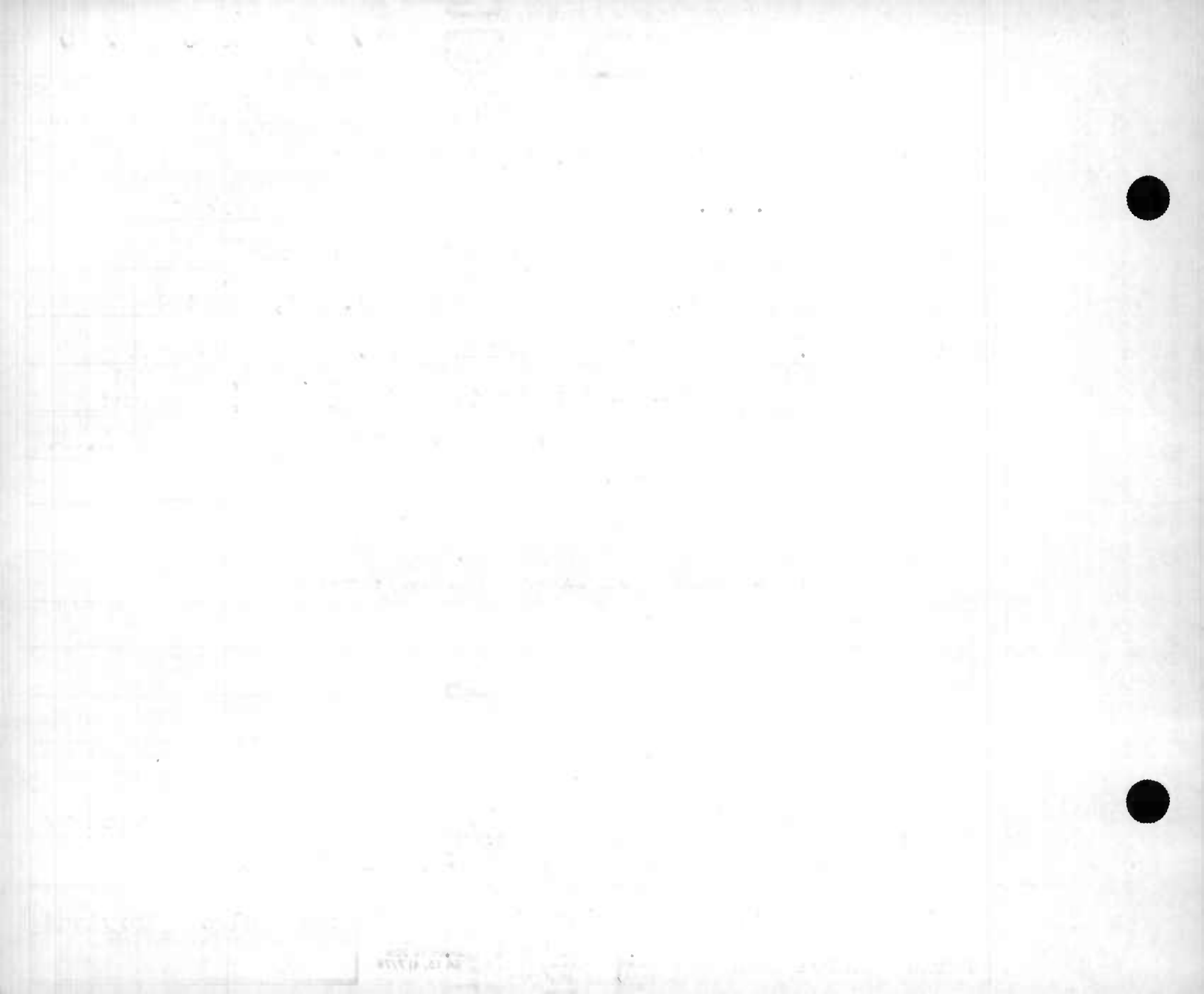


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified of once.

Item 19b G538 12/18/79 dad		STATE OF MARYLAND	
FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH		REG. NO. 7 9 2 3 3 7 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Sarah Elizabeth Dulin</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>9 30 1979</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>Apr. 10, 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>7d/604</i> MD.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>	
13c. CITY OR TOWN <i>Cordova</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John P. Dulin</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah E. Voshell</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-36-2421</i>	
17. INFORMANT <i>Rt. #1, Box 179</i>		ADDRESS <i>Cordova, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>5742</i> IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
DUE TO, OR AS A CONSEQUENCE OF (b)			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Obstructive jaundice. Osteoporosis</i>			
19a. DATE OF OPERATION <i>9/27/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>19</i>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>19</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/25/79</i> 19 to <i>9/30/79</i> 19, that (I) (we) last saw the deceased alive on <i>9/29/79</i> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>C. W. BARN</i>		22c. DATE SIGNED <i>10/2/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C. W. BARN</i>		22e. ADDRESS <i>Easton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-3-79</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton Talbot Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 08 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 23371				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George Herbert Fooks				2a. DATE OF DEATH MONTH DAY YEAR 9-21-79		2b. HOUR 35 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD			
12. CITY OR TOWN OF DEATH Gasport		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint. Engineer		15. KIND OF BUSINESS OR INDUSTRY Highway	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Caroline 16c. CITY OR TOWN Denton				17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS Deep Shore Road			
19. FATHER'S NAME FIRST MIDDLE LAST Lloyd Fooks				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Douglas					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-0749		23. INFORMANT ADDRESS Modelle Fooks, Denton, Maryland					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease (5 years)</u>									
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED				28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE					
36. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> , 19 <u>79</u> , to <u>Sept 21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.									
37. SIGNATURE <u>P. B. Rhodes</u>				38. DEGREE <u>MD</u>		39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		40. DATE SIGNED 9/22/79	
41. PHYSICIAN'S NAME (TYPE OR PRINT) P. B. RHODES				42. ADDRESS 14 N. Aurora, Eastern, Md 21601					
43. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		44. DATE 9/24/79		45. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		46. LOCATION CITY OR TOWN COUNTY STATE Eastern Talbot Md.			
47. FUNERAL DIRECTOR NAME MOORE FUNERAL HOME				48. ADDRESS DENTON, MD		49. DATE REC'D. BY REGISTRAR SEP 26 1979		50. REGISTRAR'S SIGNATURE [Signature]	

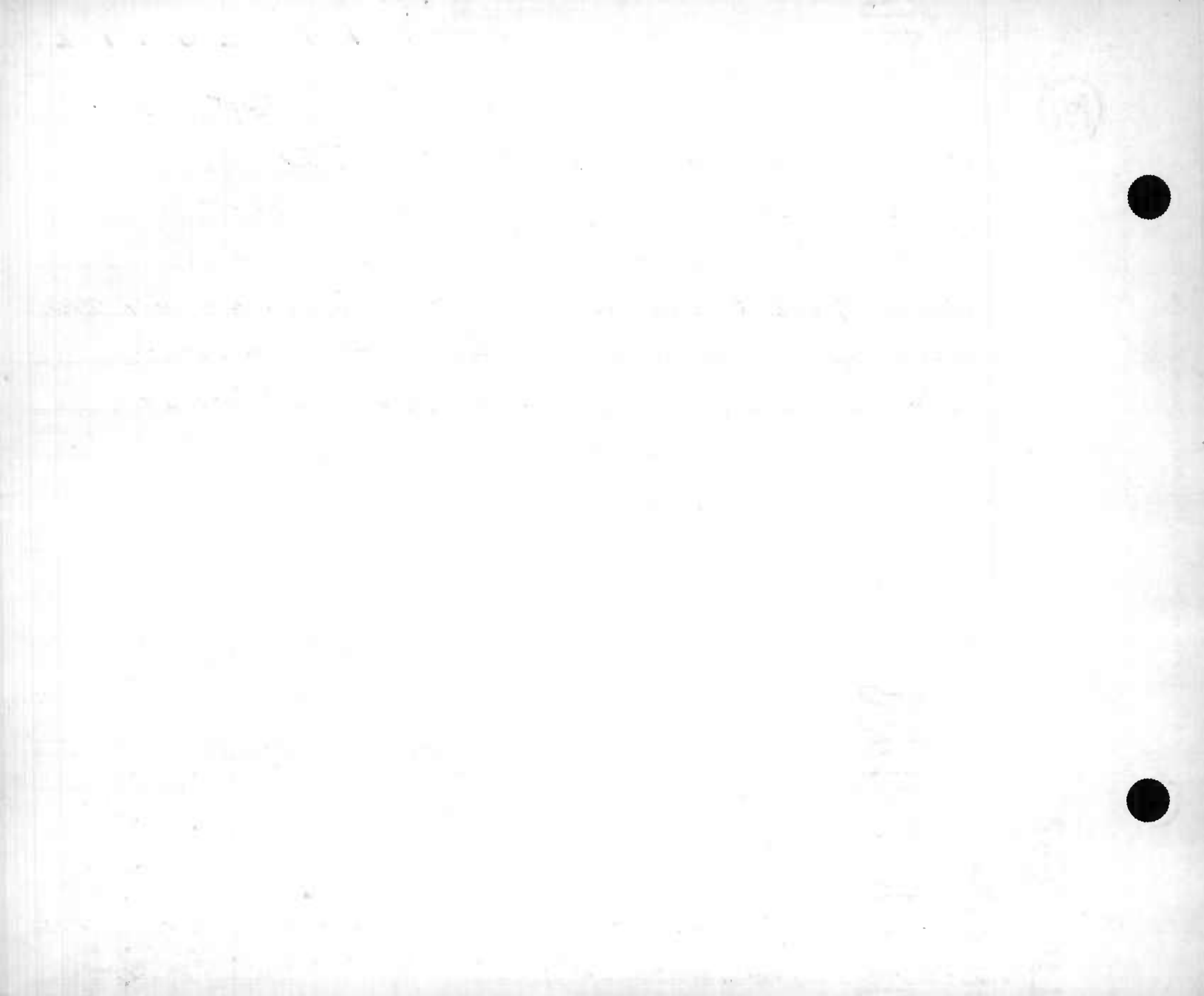
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23372	
1. DECEASED NAME (TYPE OR PRINT) Benjamin A Gibson			2a. DATE OF DEATH MONTH DAY YEAR Sept 27 79			2b. HOUR 11:40 AM					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1 7 07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
12. CITY OR TOWN OF DEATH Easton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		14b. KIND OF BUSINESS OR INDUSTRY			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD						15b. COUNTY Talbot		15c. CITY OR TOWN Easton			
16. FATHER'S NAME FIRST MIDDLE LAST William Thomas						17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Roberts					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		19. INFORMANT Bernice Skinner				ADDRESS			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)							
24a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE							
25. I certify that (I) (this hospital) attended the deceased from 7/4 1977 to Present 1979, that (I) (we) last saw the deceased alive on 9/14 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
26a. SIGNATURE P. Gregg Rhodes						DEGREE MD		26b. DATE SIGNED 9/28/79		26c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gregg Rhodes						27b. ADDRESS 141 N. Aurora St Easton, Md 21601					
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)		28b. DATE 10/1/79		28c. NAME OF CEMETERY OR CREMATORY Royal Oak		28d. LOCATION CITY OR TOWN COUNTY STATE Easton TA MD					
29. FUNERAL DIRECTOR NAME Henry H. Hobbs						ADDRESS Easton MD		30. DATE REC'D. BY REGISTRAR OCT 11 1979		31. REGISTRAR'S SIGNATURE Henry H. Hobbs	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 23373	
FOR 1- STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
Grace ADELE			September 30 1979		1:13 A M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE	WHITE	MAY 16, 1906	73		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	U.S.A.		TALBOT MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON	Memorial Hospital		HOUSEWIFE		HOME	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MARYLAND	TALBOT	NEAVITT	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				
LEVIN FISHER		M. FANNIE HILL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS		
NO		212-09-8339		JOHN W. GITH NEAVITT, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack Cardiorespiratory arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute MI</u> (c) <u>due to OR AS A CONSEQUENCE OF</u> DUE TO OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> 19 <u>79</u> to <u>9/30</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>9/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>William J. Banfield MD</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/30/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield, M.D.		22e. ADDRESS Easton, MD 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 2, 1979		23c. NAME OF CEMETERY OR CREMATORY NEAVITT CEMETERY NEAVITT TALBOT		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME <u>Carroll E. Loral, St. Michaels Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>9/30/79</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7 9 2 3 3 7 4									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Vernon		R.		Hammond				Sept. 11, 1979		7 35 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
Male		Cau.		6-27-23		56 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Pa.		U.S.A.				Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				County Roads Dept.	
Eastern		The Memorial Hospital		Laborer							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Caroline		Ridgely				River Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John A. Rueppel		Carrie R. Reed									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
yes		WW 11		213-18-4804		Mary H. Hammond		Ridgely, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1892 Metastatic Carcinoma of the uterus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 9/9/79, to 9/11/79, that (I) (we) lost saw the deceased alive on 9/11/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED					
Wm H Wood Jr		MD				9/12/79					
27d. PHYSICIAN'S NAME (TYPE OR PRINT)		27e. ADDRESS									
Wm H Wood Jr		REASON MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9-15-79		Ridgely Cemetery		Ridgely Caroline Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John E Boula's		Greensboro		SEP 19 1979		J. Boula's					

BP

SEP 11 1891

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X

Label

John A. Thompson
Caroline
River St.
X
Laborer
Label

John A. Thompson
Caroline
River St.
X
Laborer
Label

SEP 11 1891

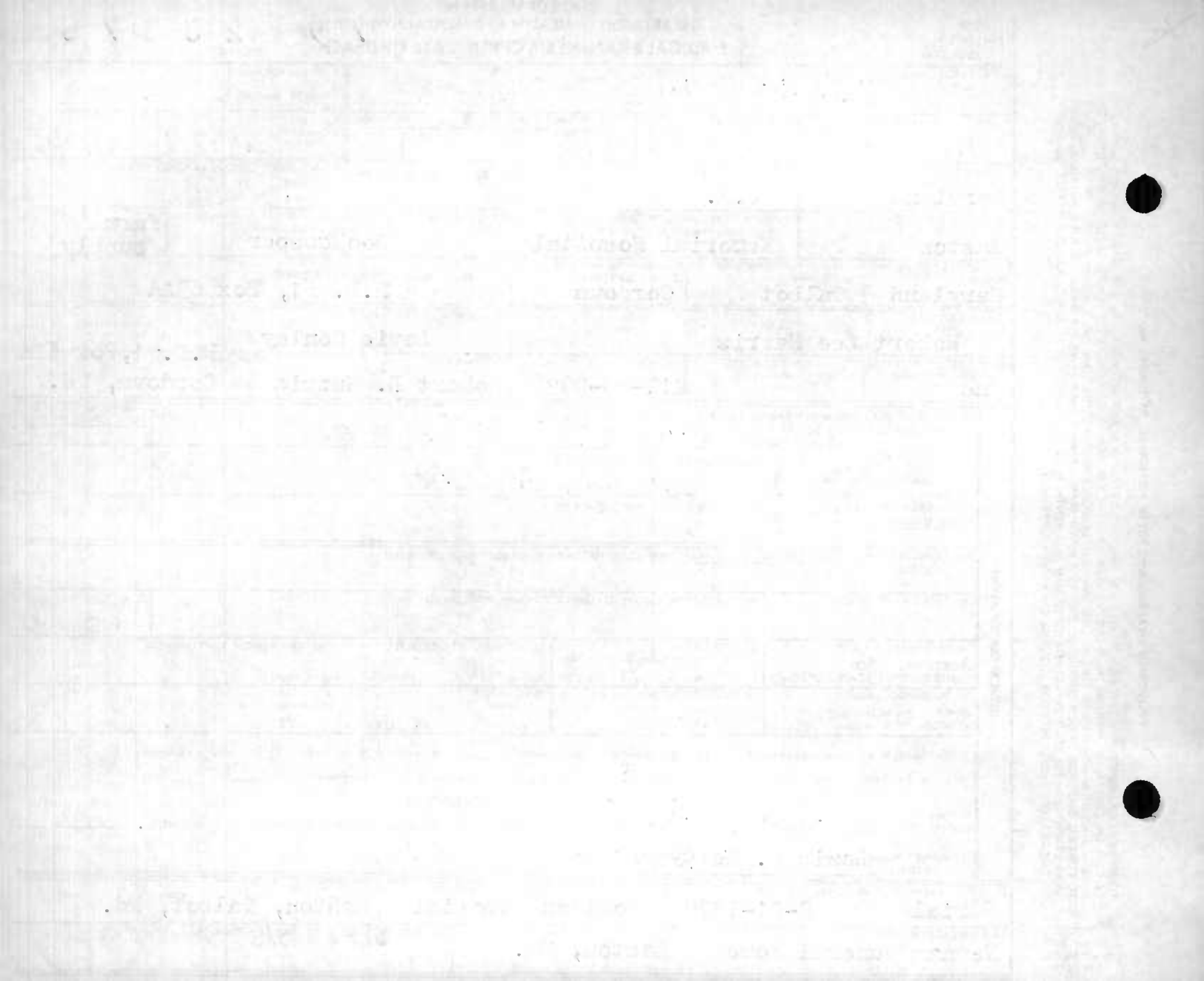
BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23375	
1. DECEASED NAME (TYPE OR PRINT) DENNIS JAMES HARRIS						2a. DATE KNOWN OF DEATH ESTIMATED 9 18 1979		2b. HOUR 8P M			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 11 DAY 13 YEAR 54	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD DOA 9-18 1979		2d. HOUR 8P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS farm industry supply			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. #1, Box 63AA			
14. FATHER'S NAME FIRST Robert MIDDLE Lee LAST Harris				15. MOTHER'S MAIDEN NAME FIRST Lovie MIDDLE Conley LAST 				ADDRESS R.D. #1, Box 62A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-60-0998		17. INFORMANT Robert L. Harris		ADDRESS Cordova, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEAD INJURIES DUE TO, OR AS A CONSEQUENCE OF (b) MOTORCYCLE ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH PO P.M. 9 18 1979			21b. TIME OF INJURY HOUR 9 P.M. MONTH 9 DAY 18 YEAR 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) STRUCK FARM IMPLEMENT						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) ROAD		21f. LOCATION STREET MR CITY OR TOWN CORDOVA COUNTY TAL STATE MD						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Lewis S. Welty			TITLE (SPECIFY) for Dep		MEDICAL EXAMINER		DATE SIGNED 9-18-79				
EXAMINER'S NAME (TYPE OR PRINT) Lewis S. Welty			ADDRESS EASTON								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-21-1979		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial			23d. LOCATION CITY OR TOWN Easton , COUNTY Talbot , STATE Md.				
24. FUNERAL DIRECTOR NAME Newham Funeral Home ADDRESS Easton, Md.				25a. DATE RECEIVED BY REGISTRAR SEP 24 1979		25b. REGISTRAR'S SIGNATURE [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 23376	
1. DECEASED NAME (TYPE OR PRINT) Estella Jenkins										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 9 23 1979 17 PM	
3. SEX F	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 11 14 90	6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 9 28 1979 5 PM		2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT. 3 - Box 445 (Home)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT #3 Box 445			
14. FATHER'S NAME FIRST MIDDLE LAST Wendell Still				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) W-				16b. SOCIAL SECURITY NO. 199-26-0283		17. INFORMANT Wife		ADDRESS Briar			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Heart Dis. 4149 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Refractory Cardiac Dis. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE R. Crane Wroth				TITLE (SPECIFY) MD				MEDICAL EXAMINER DATE SIGNED 9-24-79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 9/26/79		23c. NAME OF CEMETERY OR CREMATORY 104 town Cam.		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD			
24. FUNERAL DIRECTOR NAME James H. DeGlo				ADDRESS Easton MD		25a. DATE REC'D. BY REGISTRAR OCT 16 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

DATE

NO.

TO

FROM

SUBJECT

REFERENCE

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 3 3 7 7	
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST					MONTH DAY YEAR					12 ⁰⁵ AM	
Mary E Jump					September 20, 1979					12 ⁰⁵ AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		Caucasian		June 3, 1889		90		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON		MEMORIAL				Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS				
Maryland Talbot St. Michaels					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		207 E. Chestnut Street				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST					FIRST MIDDLE LAST						
Edward Clark Marshall					Mary Matilda Sears						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT				
No					220-26-3626		207 E. Chestnut St. St. Michaels, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Congestive Heart Failure										Month	
4140											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										8 yrs	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Renal failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET					
22a. I certify that (I) (this hospital) attended the deceased from 1872 to 9/19/79, that (I) (we) lost saw the deceased alive on 9/20/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
WM H Wood Jr					MD ATTENDING PHYSICIAN					9/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
WM H Wood Jr					EASTON, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			9-24-79		Olivet Cemetery			St. Michaels Talbot Md.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
NAME Newnam Funeral Home					ADDRESS 200 S. Harrison St. Easton, Maryland			SEP 24 1979			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 2 3 3 7 8 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) John A. LEATHAM					2a DATE OF DEATH MONTH DAY YEAR September 26, 1979			2b HOUR 10 P. M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug 31, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10 CITY OR TOWN OF DEATH Easton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) The Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b KIND OF BUSINESS OR INDUSTRY Retired	
13a STATE Delaware		13b COUNTY New Castle		13c CITY OR TOWN Townsend		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rural	
14 FATHER'S NAME FIRST MIDDLE LAST No Record					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST No Record				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) Yes		16b SOCIAL SECURITY NO. U.W. II 222-07-3699		17 INFORMANT ADDRESS Ruth Ashwell - Smyrna Rd.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 434- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Marked bilateral indirect inguinal hernia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Sept 12 19 79 , to Sept 25 19 79 , that (I) (we) last saw the deceased alive on Sept 25 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b SIGNATURE Richard F. Manegold DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 9/25/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD F. MANEGOLD					22e ADDRESS Easton, Maryland.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/28/79		23c NAME OF CEMETERY OR CREMATORY Townsend Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Townsend - N.C. - Del.			
24 FUNERAL DIRECTOR NAME ADDRESS Robert C. Hutchinson - Middletown, Md.					25 DATE REG'D BY REGISTRAR (IN REGISTRAR'S SIGNATURE) OCT 03 1979				

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

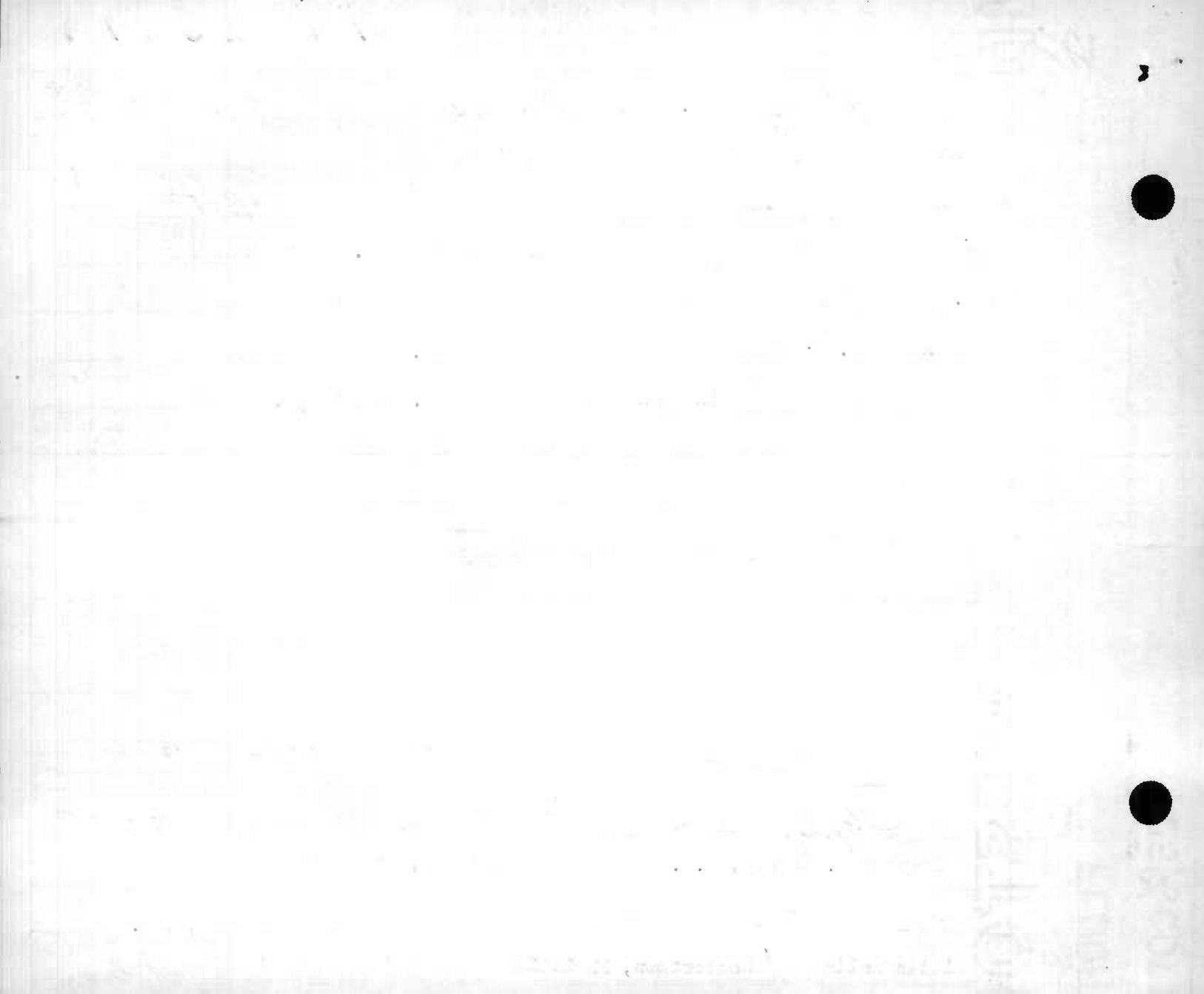
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 2 3 3 7 9	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Harry H. Morris</i>			2a. DATE OF DEATH		2b. HOUR
			MONTH DAY YEAR <i>9 16 1979</i>		<i>9:40</i> M
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 5, 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>9a/60t</i> MD.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Bank Cashier</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Kent</i>	13c. CITY OR TOWN <i>Chestertown</i>	13d. STREET ADDRESS <i>RFD Melitota</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wilbur H. Morris</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary A. Hendrickson</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>218 01 3948</i>		17. INFORMANT ADDRESS <i>Chestertown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the stomach</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1519</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 YRS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-3</i> , 19 <i>77</i> , to <i>9-14</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>9-15</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE		22c. DATE SIGNED <i>9-17-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney, M.D.</i>		22e. ADDRESS <i>Easton, MD 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/18/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chester Cemetery</i>	
23d. LOCATION CITY OR TOWN <i>Chestertown, Md.</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Willis Wells</i>		ADDRESS <i>Chestertown, MD 21620</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 19 1979</i>	
				25b. REGISTRAR'S SIGNATURE <i>Patrick McBrady</i>	

BP _____





Items 12a, 12b g536 10/10/79 g3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

2 3 3 8 0

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louise MORRIS		2a. DATE OF DEATH MONTH DAY YEAR September 17, 1979		2b. HOUR 7 A. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 4, 1906	
6. AGE (IN YEARS LAST BIRTHDAY) 73		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? USA	
9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) THE MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Cashier		12b. KIND OF BUSINESS OR INDUSTRY Retail Grocery		13a. STREET ADDRESS Hope Road	
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. CITY OR TOWN Centreville		13d. STREET ADDRESS R.D.#1, Box 7	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Clarence Chance		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Quimby		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 217-03-3379		17. INFORMANT Son		ADDRESS R.D. #1, Box 5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 4402 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) delayed amputation (c) generalized arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION 8/15/79 8/3/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.K. Gieske MD		DEGREE MD		22c. DATE SIGNED 9/17/79	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS Easton, Md. 21601			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE Sep. 19, 1979		23e. NAME OF CEMETERY OR CREMATORY Chesterfield	
23f. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md.		24. FUNERAL DIRECTOR NAME James H. Barton, Jr.		25a. DATE REC'D. BY REGISTRAR SEP 20 1979	
25b. REGISTRAR'S SIGNATURE History McCreedy		25c. REGISTRAR'S SIGNATURE			

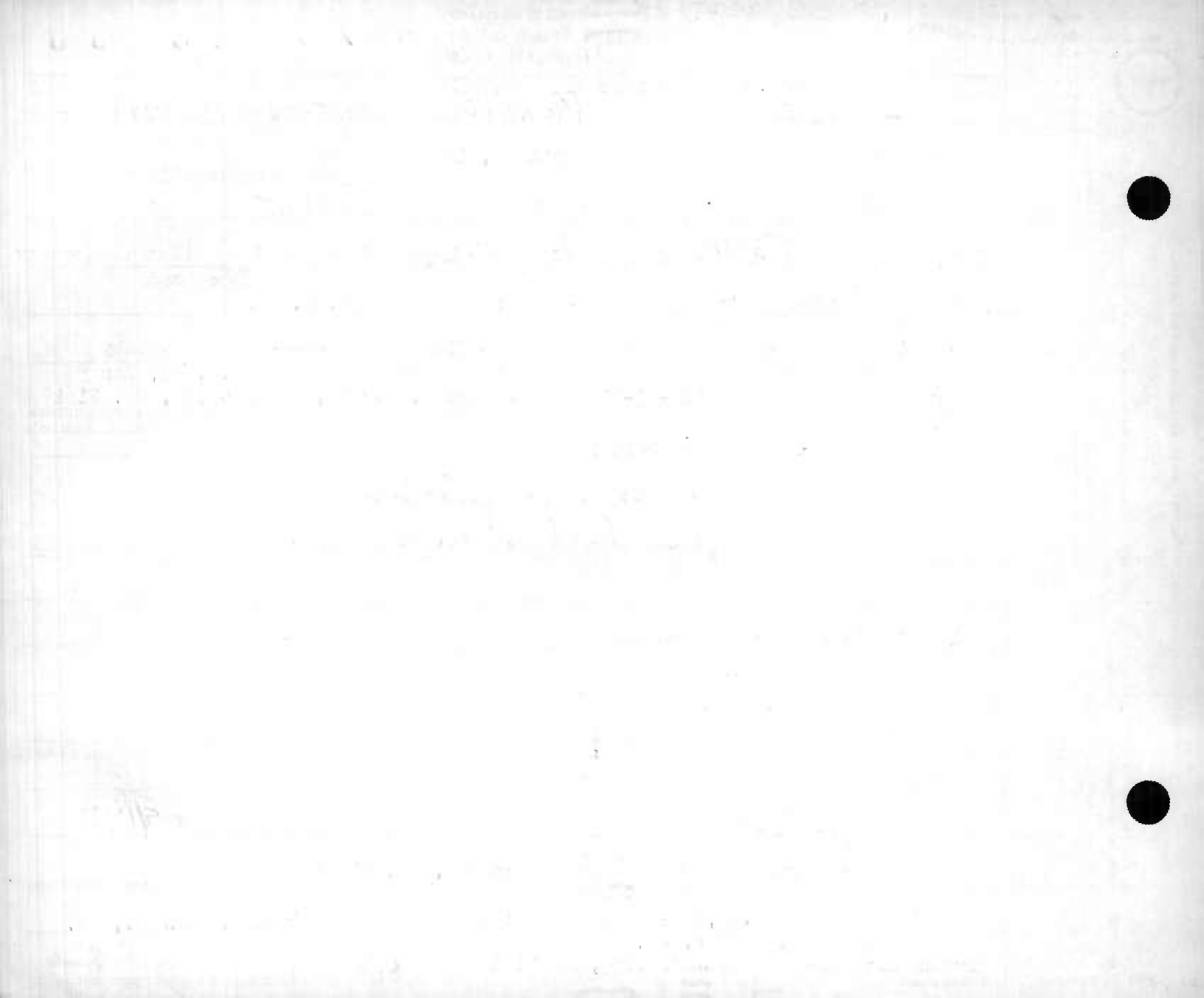
BP

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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 1- FOR
 STATE
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

23381

1. DECEASED NAME (TYPE OR PRINT)		FIRST Henry		MIDDLE A.		LAST MOTTE		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 9		DAY 26		YEAR 1979		2b. HOUR 5P			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH 12		DAY 30		YEAR 68		6. AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		NEVER MARRIED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT									
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY FARM													
13a. STATE MD		13b. COUNTY CAROLINE		13c. CITY OR TOWN PRESTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 2 B 87B											
14. FATHER'S NAME FIRST William				MIDDLE Mote				15. MOTHER'S MAIDEN NAME FIRST Lillian				MIDDLE Marine				LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218-58-0639				17. INFORMANT Marilyn Murray				ADDRESS Rt. 2, Box 87B, Preston, Md. 21655							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <u>ASCVD</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION SSI #				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 05003867180N												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Louis D. Motte				TITLE (SPECIFY) M.D. J.W.D.				MEDICAL EXAMINER				DATE SIGNED 9-26-79							
EXAMINER'S NAME (TYPE OR PRINT) WELTK				ADDRESS EASTON															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept. 29, 1979				23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery				23d. LOCATION CITY OR TOWN FEDERALSBURG, CAROLINE				COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.				ADDRESS FEDERALSBURG, MD.				25a. DATE REC'D. BY REGISTRAR OCT 01 1979				25b. REGISTRAR'S SIGNATURE [Signature]							

BP



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 3 3 8 2				
1. DECEASED NAME (TYPE OR PRINT)					REG. NO.				
FIRST <i>Charles</i> MIDDLE <i>William</i> LAST <i>Nethken, Sr.</i> <i>Charles William Nethken</i>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>Sept 7 79 3 3 A M</i>				
3. SEX <i>Male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 15, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>serviceman for</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Telephone Co.</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY <i>MD. Q.A. Co. Grasonville</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Rt#1 Box 88 G, Grasonville, Md. Chesterniver Bea</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William L. Nethken</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minne S. Dick</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>					16b. SOCIAL SECURITY NO. <i>212-03-6770</i>		17. INFORMANT ADDRESS <i>Audrey Lee Nethken, Rt#1 Box #88 G Grasonville, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-19</i> 19 <i>79</i> , to <i>9-7</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>9-5</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9-8-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN P. CARNEY MD.</i>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL <i>burial</i>			23b. DATE <i>9-10-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton, Talbot Co. Md.</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Helffenbein-Hubbard Funeral Home, Chester, Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John M. Brady</i>	

BP _____

DHMM-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

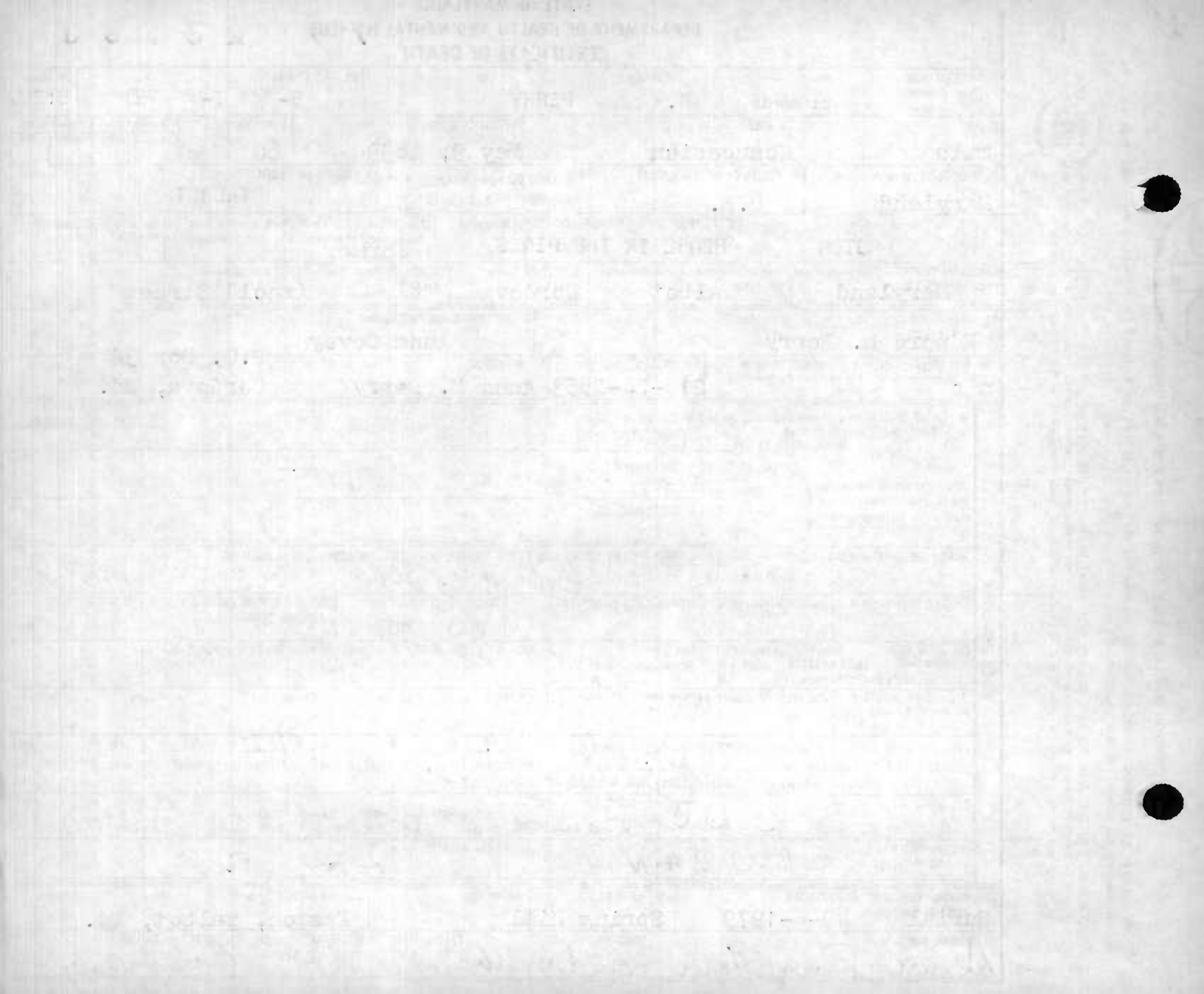
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23383

1. DECEASED-NAME (Type or print) EDWARD N. PERRY			2a. DATE OF DEATH 9 Month 3 Day 79 Year			2b. HOUR 8:20 M			
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH May 9, 1899		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Arnold Street	
14. FATHER'S NAME First Middle Last Edward R. Perry			15. MOTHER'S MAIDEN NAME First Middle Last Anna Covey			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16a. SOCIAL SECURITY NO. 215-26-2553		17. INFORMANT Anna M. Perry			17. ADDRESS P.O. Box 34 Cordova, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: 0389 SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last. GANGLIENIZ FOOT (b) FOOT DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) COPD, CORONARY VASCULAR INSUFFICIENCY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natality medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1979 , 19____, to 9/3/79 , 19____, that (I) (we) lost saw the deceased alive on 8/3/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. W. Bain DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/4/79			
22d. PHYSICIAN'S NAME (Type) C W BAIN				22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-6-1979		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Talbot, Md.			
24. FUNERAL DIRECTOR Newman Funeral Home				ADDRESS Easton, Md.		25a. REC'D BY REGISTRAR DATE SEP 10 1979		25b. REGISTRAR'S SIGNATURE Barney McCreedy	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 383-3580.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 3 3 8 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Medford L. Price</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>9-14-79</u>			2b. HOUR <u>4:35</u> AM	
3 SEX <u>Male</u>		4 RACE <u>Cau.</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>5-9-04</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>TALBOT</u> MD.			
10 CITY OR TOWN OF DEATH <u>EASTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Maryland Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Barber</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Caroline</u> 13c. CITY OR TOWN <u>Greensboro</u>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Cedar Lane</u>		
14 FATHER'S NAME FIRST MIDDLE LAST <u>George Price</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary E. Sweeney</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>212-22-1208</u>		17. INFORMANT ADDRESS <u>Hannah Price Greensboro, Md.</u>					
11. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>5 yrs.</u> <u>yrs.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>— P.M. — 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>—</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET <u>—</u>		CITY OR TOWN <u>—</u>		COUNTY <u>—</u> STATE <u>—</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> 19 <u>79</u> , to <u>9/14</u> 19 <u>79</u> , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on <u>9/14</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> did (did not) view the body after death.									
22b. SIGNATURE <u>Albert T. Dawkins Jr.</u> DEGREE <u>M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/14/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERT T. DAWKINS JR</u>					22e. ADDRESS <u>14 N. AURORA ST EASTON, MARYLAND 21801</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>9-17-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro Cemetery Greensboro</u>		23d. LOCATION CITY OR TOWN <u>Caroline</u>		STATE <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>John E. Boula's Greensboro</u>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 19 1979</u>				

BP

x

George Price
Mrs. Caroline Brown
N. Cedar Lake
Harry L. Green

113-12-1222 Nathan Selig Greenboro, N.C.

113-12-1222 Nathan Selig Greenboro, N.C.

DO NOT WRITE
IN THESE SPACES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 3 3 8 5

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE M. RILEY			2a. DATE OF DEATH MONTH DAY YEAR September 7 1979			2b. HOUR 11:25 AM			
3 SEX female		4 RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1891		6. AGE (IN YEARS (LAST BIRTHDAY)) 87		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 209 Adkins Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas R. Marshall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie J. Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-32-8045		17. INFORMANT ADDRESS Corinne R. Buzbee see item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiogenic shock + 3° heart block								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction								1 hour	
DUE TO, OR AS A CONSEQUENCE OF (c) coronary artery disease (ASCVD)								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. none									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —					
22a. I certify that (I) (this hospital) attended the deceased from 9/7 19 79 to 9/7 19 79 , that (I) (we) saw the deceased alive on 9/7 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Robert T. Dawkins Jr.				DEGREE —				22c. DATE SIGNED 9/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. DAWKINS JR. MD				22e. ADDRESS 14 N. AURORA ST. EASTON, MD 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-1979		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Church		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Del.			
24. FUNERAL DIRECTOR NAME Newman Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR SEP 11 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					7 9 2 3 3 8 6				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <i>William W. Sampson</i>					MONTH DAY YEAR <i>9-19-79</i>				
3 SEX <i>Male</i>					2b. HOUR <i>5 P.M.</i>				
4 RACE <i>Negro</i>					5. DATE OF BIRTH				
MONTH DAY YEAR <i>Sept. 4, 1908</i>					6 AGE (IN YEARS LAST BIRTHDAY)				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Dorchester Co.</i>					7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.				
10 CITY OR TOWN OF DEATH <i>Easton</i>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Supervisor</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>Acme Markets</i>				
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Dorchester</i>				
13c. CITY OR TOWN <i>Hurlock</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Algie Francis Sampson</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucenia McGlotten</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO <i>220-09-9945</i>				
17. INFORMANT <i>Mrs. Clara E. Sampson</i>					ADDRESS <i>Maryland 21643</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC RESPIRATORY FAILURE</i> <i>185-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>ACUTE MYOCARDIAL INFARCTION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ACUTE MYOCARDIAL INFARCTION</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22a. SIGNATURE <i>John J. Devine</i>					22b. ADDRESS <i>Easton, Maryland 21601</i>				
22c. DATE SIGNED					22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Devine</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>					23b. DATE <i>Sept. 22, 1979</i>				
23c. NAME OF CEMETERY OR CREMATORY <i>Petersburg Cemetery</i>					23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hurlock, Dorchester, Maryland</i>				
24. FUNERAL DIRECTOR NAME ADDRESS <i>Trumpton-Humbert Box 43 Federalburg, Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>SEP 26 1979</i>				
25b. REGISTRAR'S SIGNATURE <i>John J. Devine</i>									

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

2 3 3 8 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Agnes C. Sanger			2a. DATE OF DEATH MONTH DAY YEAR Sept. 8, 1979			2b. HOUR 5:40 P.M.		
3 SEX female	4 RACE caucasian	5 DATE OF BIRTH MONTH DAY YEAR Mar. 5, 1916	6 AGE (IN YEARS LAST BIRTHDAY) 63			7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10 CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Talbot			13c. CITY OR TOWN Easton		
14 FATHER'S NAME FIRST MIDDLE LAST Daniel Combs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Tilghman			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 062-01-7551			17 INFORMANT ADDRESS Agnes T. S. Boyd		
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5570 Mesenteric thrombosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
DUE TO, OR AS A CONSEQUENCE OF (b) _____			DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary emphysema								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 8-20 , 19 79 , to 9-8 , 19 79 , that (2) (we) last saw the deceased alive on 9-8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Robert W. Trever, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-8-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.						22e. ADDRESS RD3 Easton Md. 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 9-9-1979			23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		
23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			COUNTY Sussex			STATE Delaware		
24 FUNERAL DIRECTOR NAME Newman Funeral Home						ADDRESS Easton, Md.		
25a. DATE REGO. BY REGISTRAR SEP 13 1979						25b. REGISTRAR'S SIGNATURE [Signature]		

BP _____

DHMM-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 2 3 3 8 8				
1. DECEASED NAME (TYPE OR PRINT)					REG. NO.				
Edward John Schmitt					2a. DATE OF DEATH MONTH DAY YEAR 9-9-79				
3. SEX Male					2b. HOUR 3:02 PM				
4. RACE Cau.					5. DATE OF BIRTH MONTH DAY YEAR 8-9-14				
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.					7. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Easton					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber					12b. KIND OF BUSINESS OR INDUSTRY Barbering				
13a. STATE Md.					13b. CITY OR TOWN Greensboro				
14. FATHER'S NAME FIRST MIDDLE LAST Frank Schmitt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Henschel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 213-14-6480				
17. INFORMANT ADDRESS Dora V. Schmitt Greensboro, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction									
410- DUE TO, OR AS A CONSEQUENCE OF (b) ASHED									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus, Genl Arteriosclerosis									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 79 9/9 75									
22. I certify that (I) (this hospital) attended the deceased from 9/9/79 to 9/9/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Wood									
22b. DEGREE MD									
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. DATE SIGNED 9/9/79									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) WOOD									
22f. ADDRESS EASTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									
23b. DATE 9-13-79									
23c. NAME OF CEMETERY OR CREMATORY Greensboro									
23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Caroline Md.									
24. FUNERAL DIRECTOR NAME John E. Boula's									
25. DATE REC'D. BY REGISTRAR 25. REGISTRAR SIGNATURE SEP 13 1979									

BP

1917

1917

Mr. Caroline Thompson x White Box No. 1.

Frank Schmidt Marie Schmidt

Transboro, N.J. 1917-1918

Item 8 g539 1/14/80 gj

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

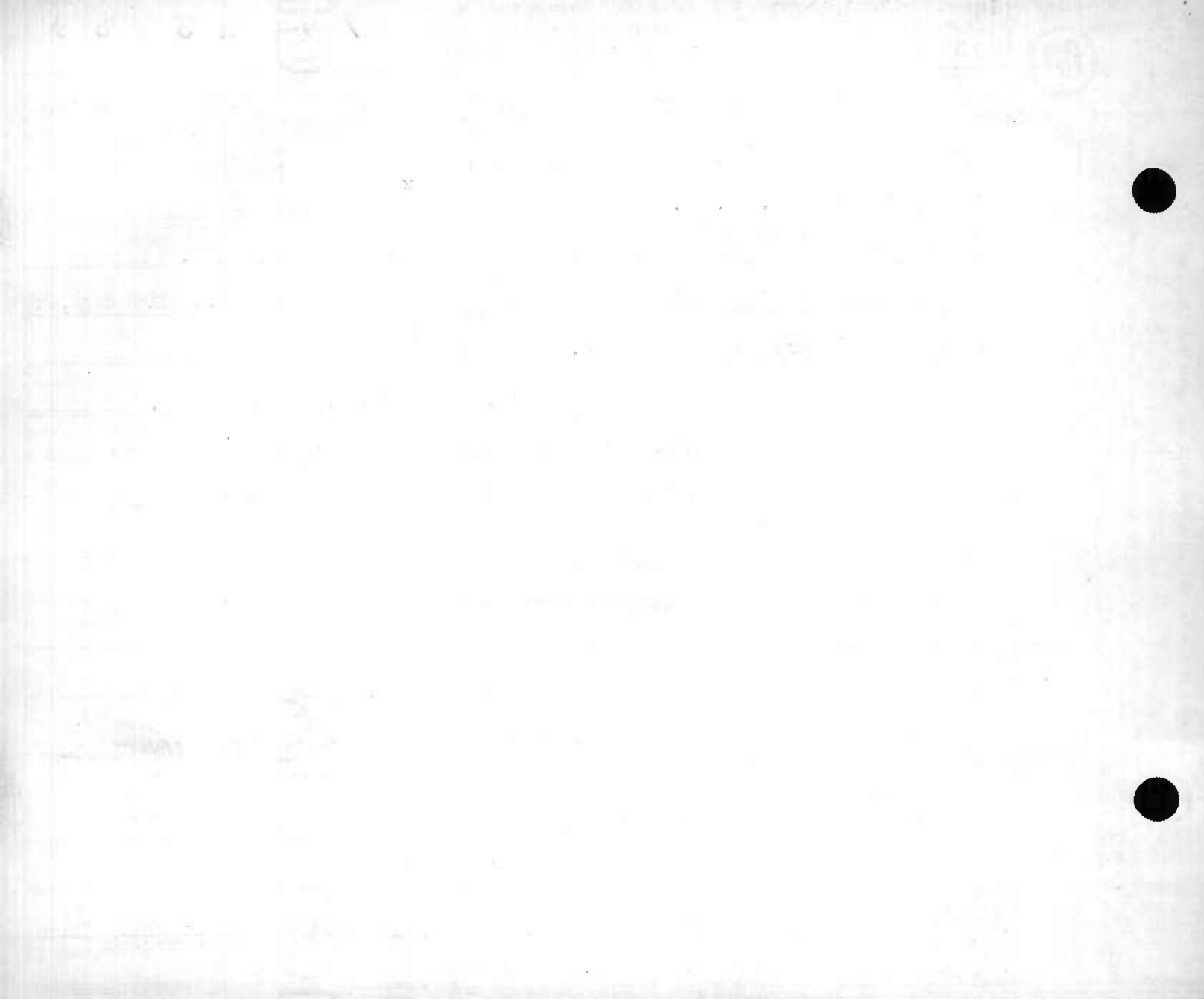
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George ALBERT Shave			2a. DATE OF DEATH MONTH DAY YEAR 9-29-79			2b. HOUR 4:35A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 21, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Probation Off.		12b. KIND OF BUSINESS OR INDUSTRY Law	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely		
14. FATHER'S NAME FIRST MIDDLE LAST George Albert Shane Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Noble				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs. Inez Long, Denton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/28/79	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/28/79</u> 19 <u>79</u> to <u>9/29/79</u> 19 <u>79</u> , that (I) (we) (we) (we) saw the deceased alive on <u>9/28/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P. GREGG RHODES MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. GREGG RHODES MD						22e. ADDRESS 14 N. Aurora			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/1/79		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md			
24. FUNERAL DIRECTOR NAME MOORE FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR OCT 08 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



M

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

2 3 3 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Devey Collier Smith</i>			2a. DATE OF DEATH MONTH <i>9</i> DAY <i>7</i> YEAR <i>1979</i>			2b. HOUR <i>1:45</i> PM				
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>May</i> DAY <i>4</i> YEAR <i>1924</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Grasonville</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.				
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MARINE</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>Queen Anne's</i>		13c. CITY OR TOWN <i>Chester</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST <i>David</i> MIDDLE <i>Smith</i> LAST <i>Smith</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Sara</i> MIDDLE <i>Collier</i> LAST <i>Collier</i>			16a. STREET ADDRESS <i>Box 419 Marling Farms</i>			16b. <i>Md. 21619</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-16-5289</i>		17. INFORMANT <i>Alice Benton Smith</i>		ADDRESS <i>Chester, Md. Box 419 Marling Farms</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lungs</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 mo</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>5-19</i> , 19 <i>79</i> , to <i>9-7</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>4-7</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7-8-79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen P. Carney</i>			22e. ADDRESS <i>Dutchmens Lane Easton, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>9-8-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION CITY OR TOWN <i>Washington</i> COUNTY <i>Md.</i> STATE			
24. FUNERAL DIRECTOR NAME <i>Heltenstein-Hubbard</i> ADDRESS <i>Chester Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>SEP 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry M. ...</i>					

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE CHIEF OF THE FUNERAL HOME SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23391

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Grace Matilda Spencer			DATE OF DEATH 19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Female	White	10-10-1893	85 YRS.	MONTHS DAYS HOURS MIN.		9-18-79	5P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.				Talbot MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospital			Homemaker			
13a. STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland			Talbot		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		308 Elm Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Archibald Spencer			FIRST MIDDLE LAST Sallie Diefenderfer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			216-54-9082		Doris J. Schwaninger Trappe, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Calcific Aortic Stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Louis D. Helly			M.D. for DME			7-18-79		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Louis WELTY			Easton Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		9-21-79		Spring Hill		Easton Talbot Maryland		
24. MEDICAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Newnam Funeral Home				200 S. Harrison St. Easton, Maryland		SEP 24 1979		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1 - STATE REGISTRAR					7 9 2 3 3 9 2				
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH MONTH DAY YEAR				
Henrietta R. Trott					Sept 10, 1979				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b HOUR	
Female		Negro		9 19 92		86 YRS		4 25 M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
MD		USA				Talbot			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Easton		The Memorial Hospital				Domestic			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
13a STATE MD 13b COUNTY Talbot 13c CITY OR TOWN McDaniel					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 53		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Tom K					Florence Drake				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS		
No					216 142444		Henrietta Batson		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2500 UREMIA + DIABETES									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE DIABETES									1 WK
DUE TO, OR AS A CONSEQUENCE OF (c) YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) LEFT BKA FOR DIABETIC GANGRENE									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
9-5-79		DIABETIC GANGRENE			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE					DEGREE			22c DATE SIGNED	
R. H. Drake MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
		9/14/79		Chesapeake		McDaniel Talbot MD			
24 FUNERAL DIRECTOR					25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Henry H. O'Connell					OCT 11 1979		Henry H. O'Connell		





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 7 9 2 3 3 9 3
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

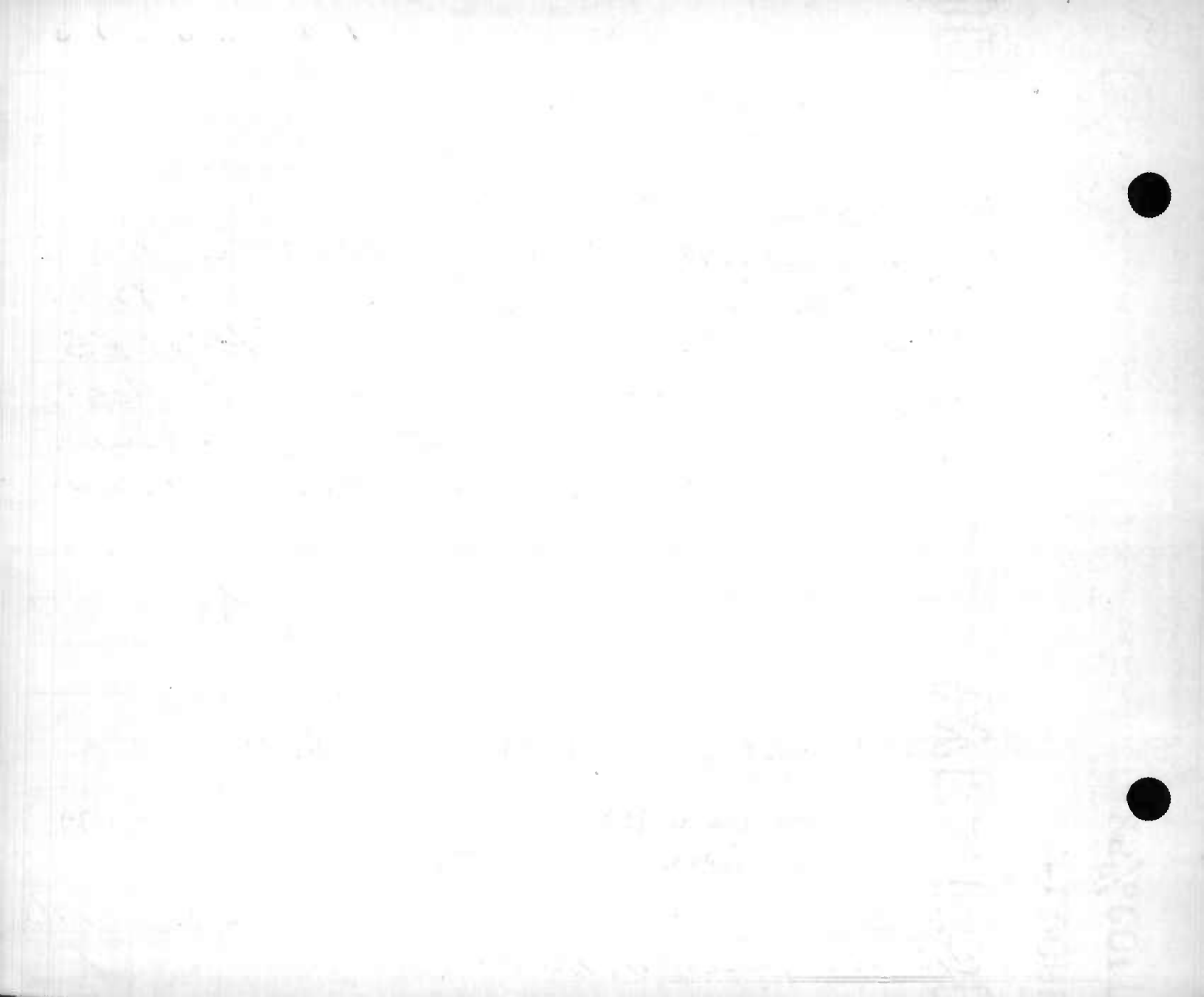
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLA MAE TURNER			2a. DATE OF DEATH MONTH DAY YEAR Sept 11, 1979			2b. HOUR 1 PM M			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAR. 14, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) TRENTON, N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY CAROLINE 13c. CITY OR TOWN Federalburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS GENERAL DEL.					
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES BEULAH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALIE HAYNES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ADDRESS Records - MEMORIAL HOSP.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/10/79 , 19____, to 9/11/79 , 19____, that (I) (we) lost saw the deceased alive on 9/11/79 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE C.W. Bain MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.W. BAIN		22e. ADDRESS Easton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/16/79		23c. NAME OF CEMETERY OR CREMATORY FEDERAL HILL		23d. LOCATION CITY OR TOWN COUNTY STATE FEDERAL HILL CAROLINE MD.			
24. FUNERAL DIRECTOR NAME Charles Denton ADDRESS Denton, Md.		25a. DATE REC'D. BY REGISTRAR SEP 18 1979		25b. REGISTRAR'S SIGNATURE Patricia Kelly					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 3 3 9 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BridgeTT G. Wagner			2a. DATE OF DEATH MONTH DAY YEAR Sept. 30, 1979		2b. HOUR 6 40 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1984		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Devlin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann McGahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 276-26-4853		17. INFORMANT ADDRESS Rt. # 1, Box 107 Mary W. Ridgeway Oxford, Maryland	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 d					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Ascd + Pneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 79 , to 9/30 , 19 79 . that (I) (we) last saw the deceased alive on 9/29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald T. Lewers				22c. DATE SIGNED 9/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald T. Lewers M.D.				22e. ADDRESS Dutchmans Lane, Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-2-79		23c. NAME OF CEMETERY OR CREMATORY Holy Cross	
23d. LOCATION CITY OR TOWN COUNTY STATE Cleveland Cuyahoga Ohio		23e. NAME OF CEMETERY OR CREMATORY Holy Cross			
24. FUNERAL DIRECTOR NAME Newham Funeral Home		24b. ADDRESS 200 S. Harrison St. Easton, Maryland		24c. DATE REC'D BY REGISTRAR Oct 3 1979	
25. REGISTRAR'S SIGNATURE [Signature]					

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Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 2 3 3 9 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Charles F. Watson						9-28-79			5:10 M
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		Caucasian		Apr. 25, 1912		67			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				Talbot MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial				Salesman		Liquor	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Maryland					Talbot		Oxford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Frank Watson					Lola Claffey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS		
Yes					WW 11		Dorothy B. Watson Pleasent Street Oxford, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma of the lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis of Aorta with Angina</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>79</u> , to <u>9/28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>9/28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Wm Wood</u>			MD					9/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Wm Wood			EASDA, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		9-29-79		Delmarva Crematory		Lewes Sussex Delaware			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		200 S. Harrison St. Easton, Maryland		OCT 03 1979		<u>H. H. H. H.</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 2 3 3 9 6		
1. STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Mary M. Wayman					2a. DATE OF DEATH MONTH DAY YEAR Sept. 14, 1979			2b. HOUR 6:00 M				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN 24, 1894		6. AGE (IN YEARS LAST BIRTH DAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.						
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE				
13a. STATE MARYLAND		13b. COUNTY CAROLINE		13c. CITY OR TOWN RIDGELY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS GENERAL DELIVERY				
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE (NMN) WILSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA (NMN) HORNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-20-4870		17. INFORMANT ADDRESS RECORDS OF MEMORIAL HOSP EASTON, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension & Gastroesophageal reflux												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPTIC? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from 9/13 19 79 , to 9/14 19 79 , that (I) (we) last saw the deceased above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Wm H Wood					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 9/17/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Wood					22e. ADDRESS Easton Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-19-1979		23c. NAME OF CEMETERY OR CREMATORY SPRINGGROVE CEMT.			23d. LOCATION CITY OR TOWN COUNTY STATE DENTON, CAROLINE, MARYLAND				
24. FUNERAL DIRECTOR NAME Cliffice, Denton, Md.					24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		

Alfred W. Thompson

1911

For the purpose of

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